COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 5261-05
Bill No.: HCS for HB 1662
Subject: Medicaid; Social Services Department; Insurance - Medical
Type: Original
Date: April 3, 2014

Bill Summary: This proposal changes the laws regarding health care coverage.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
General Revenue	(Greater than $709,431)	Could be less than $4,808,638	Could be less than $5,024,079
Total Estimated Net Effect on General Revenue Fund	**(Greater than $709,431)**	**Could be less than $4,808,638**	**Could be less than $5,024,079**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
Various Other Funds	$0	$3,309,642	$3,448,646
Total Estimated Net Effect on Other State Funds	**$0**	**$3,309,642**	**$3,448,646**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 17 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
Federal*	$0	$0	$0
Total Estimated Net Effect on All Federal Funds	**$0**	**$0**	**$0**

*** Income, savings, expenditures and losses exceed $15 million annually and net to $0.**

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
General Revenue	4.5	4.5	4.5
Federal	4.5	4.5	4.5
Total Estimated Net Effect on FTE	**9**	**9**	**9**

☐ Estimated Total Net Effect on All funds expected to exceed $100,000 savings or (cost).

☒ Estimated Net Effect on General Revenue Fund expected to exceed $100,000 (cost).

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
Local Government	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

§191.875 - Price Transparency:

Officials from the **Department of Social Services (DSS) - MO HealthNet Division** state MO HealthNet has most procedure fees currently available on the internet. MO HealthNet may receive more calls at the participant and provider call centers if help is needed to interpret the fee schedules, but it is anticipated that this could be handled with current staff. Therefore, there is no fiscal impact to MO HealthNet from this section.

Officials from the **DSS - Division of Legal Services (DLS)** state this section requires healthcare providers to provide patients with cost estimates for goods and services provided. This provision appears to have no fiscal impact on the DLS.

Officials from the **Department of Mental Health (DMH)** state this section proposes that health care providers provide an estimate of the cost of health care services within three (3) days of a patient request. The DMH assumes that this requirement would be absorbed within the existing administrative functions of the DMH providers. Therefore, the DMH anticipates no fiscal impact.

§208.166 - Statewide managed care for current populations:

Officials from the **DSS - MO HealthNet Division (MHD)** provide the following assumptions:

Section 208.166.5.(1) extends the MO HealthNet Managed Care program statewide by January 1, 2015, for all eligibility groups currently enrolled in a managed care plan as of January 1, 2014. MHD assumes the intent of this language is to expand Managed Care statewide.

MO HealthNet would require an additional eight (8) FTE to implement Managed Care statewide. These FTE would include: a Social Services Manager II ($50,088 annually); a Management Analysis Specialist II ($41,016 annually); a Medicaid Unit Supervisor ($41,016 annually); a Program Development Specialist ($39,480 annually); a Correspondence and Information Specialist ($34,092 annually); and three (3) Medicaid Technicians ($31,800 annually, each). MHD assumes that additional rental space would be needed, as there are not eight (8) open cubicles at the Howerton Building. The total cost for staff, fringe and office space for FY15 (10 months) would be $476,102. FY16 costs would be $492,757, and FY17 costs would be $498,187.

ASSUMPTION (continued)

The effective date of July 1, 2015 follows the normal Managed Care Procurement schedule. It is anticipated that the Centers for Medicare and Medicaid Services (CMS) will require all current enrollees as well as new enrollees to go through open enrollment and choose a plan. The cost for enrollment packets would be $510,140.

MO HealthNet estimates that there would be an actuarial cost to evaluate the capitation rates in the amount of $100,000.

There would also be a one-time cost for Medicaid Management Information System (MMIS) changes to cover the additional counties and population. The estimated cost for this would be $550,000. This assumes a new region will be created and up to 3 new health plans will be added.

The cost to administer statewide managed care with the current MO HealthNet population would be as follows:

FY15: $476,101 for Salaries, Fringe and E&E (10 months)
$510,140 Enrollment Packets
$100,000 for actuarial costs
$550,000 for MMIS costs
Total: $1,636,241

FY16: $492,757 for Salaries, Fringe and E&E
$229,000 for additional Enrollment Packets
$721,757

FY17: $498,187 for Salaries, Fringe and E&E
$229,000 for additional enrollment packets
$727,187

FY15 (10 mos.) > = $1,636,241 (GR > = $818,120; Federal > = $818,121)
FY16: $721,757 (GR $360,878; Federal $360,879)
FY17: $727,187 (GR $363,593; Federal $363,594).

Additionally, MO HealthNet assumes that there will be a six-month savings in FY16 of $23,403,457 by moving the current fee-for-service population to Managed Care. For FY17 there will be a savings of $24,386,401. Savings will be in Federal, GR and Other Funds, including Federal Reimbursement Allowance, Ambulance Federal Reimbursement Allowance and Health Initiatives Fund.

FY16: $23,403,457 (GR $5,202,890; Other Funds $3,309,642; Federal $14,890,925)
FY17: $24,386,401 (GR $5,421,411; Other Funds $3,448,646; Federal $15,516,344).

ASSUMPTION (continued)

Officials from the **DSS - Division of Legal Services (DLS)** state this section extends the current managed care program statewide and adds a requirement that MO HealthNet providers be reimbursed within 40 days of submitting a clean claim. While the statutory 40-day payment requirement may create hearing rights to the Administrative Hearings Commission, under 208.153, RSMo, well over 99 percent of clean claims are paid within 30 days. The Attorney General's office represents the Department of Social Services before the Administrative Hearing Commission (AHC). Therefore, this provision does not have a fiscal impact on DLS. DLS defers to the Attorney General's office's analysis of the fiscal impact of this legislation on their office.

Oversight assumes the **Office of Attorney General (AGO)** can absorb any potential costs arising from this proposal with existing resources. If the workload increases significantly, the AGO may request additional funding through the appropriations process.

Officials from the **DMH** state the proposed legislation extends the current Managed Care Program statewide, effective July 1, 2015, for all eligibility groups currently enrolled in a managed care plan. The current Managed Care Program carves out the following DMH care management services when provided by a DMH certified provider: Community Psychiatric Rehabilitation, Comprehensive Substance Abuse Treatment and Rehabilitation, Targeted Case Management, and Developmental Disabilities waiver services. Based on the current proposed language, DMH assumes that the Department of Social Services will continue to carve out the DMH care management services as they do in the Managed Care Program today.

However, expanding managed care puts the state at risk for losing the clinic Upper Payment Limit (UPL) supplemental payments made to the Community Mental Health Centers (CMHCs). To address this potential risk, the proposed language in section 208.166.5(3) maintains the clinic UPL supplemental payment level by requiring the Department of Social Services to develop a transitional Medicaid payment plan prior to implementation of the managed care expansion to continue and preserve the current Medicaid payments for CMHCs. State Fiscal Year 2014 Clinic UPL Supplemental payments are $10.8 million ($4.1 million State; $6.7 million Federal).

DMH is responsible for the state portion of the current clinic UPL supplemental payments, and assumes the current UPL payment levels would continue to be the responsibility of DMH through the Managed Care Program. It is unknown if this payment level would have to be incorporated into the CMHCs within the current managed care counties. If it is intended that managed care reimbursement be consistent for the current managed care areas and the statewide expansion areas, there may be an impact on the current managed care rates. If DMH is required to pay the state portion of UPL payments for CMHCs within the current managed care counties, there would be a cost to the DMH.

ASSUMPTION (continued)

Section 208.166.5.(2) continues pharmacy coverage through the MO HealthNet fee-for-service program. The pharmacy benefit is currently carved out of Managed Care. Therefore, there will be no fiscal impact to MHD.

Section 208.166.5.(3) states the department shall develop a transitional Medicaid payment plan prior to July 1, 2015, if necessary, for the purpose of continuing and preserving payments consistent with current Medicaid levels for community mental health centers (CMHCs), which act as administrative entities for the department of mental health and serve as safety net providers. The department shall create an implementation working group consisting of CMHCs, the department of mental health and managed care organizations in the MO HealthNet program.

If managed care reimbursement is to be consistent for the current managed care areas and the statewide expansion areas, there may be an impact to the current managed care rates. There would be an unknown fiscal impact as MHD does not have comparisons of what CMHCs are being paid in managed care today as compared to CMHC reimbursement rates with the implementation of the Clinic UPL.

Section 208.166.6. states no MO HealthNet managed care organization shall refuse to contract with any willing provider. This will have no impact on MO HealthNet.

Section 208.166.7 requires the state to provide a biannual analysis of managed care organizations to ensure such organizations are meeting required metrics, goals and quality measurements. MHD estimates the cost to be unknown, greater than $200,000 to hire a contractor to complete this work.

§208.952 - Joint Committee on MO HealthNet:

Officials from the **DSS-MHD** state this section establishes the duties of the Joint Committee on MO HealthNet. There may be an unknown cost to MO HealthNet to provide the studies, data and results required in this section.

§208.999 - Managed Care Organizations:

Officials from the **DSS-MHD** state the proposed legislation establishes additional reporting requirements for the health plans and the DSS. It is assumed that managed care expenditures paid through capitation rates would increase at least $100,000 for the health plans' additional administrative expenses. MO HealthNet's actuary assumes that the actuarial cost to evaluate this program change to the managed care capitation rates will be no more than $25,000.

ASSUMPTION (continued)

This legislation requires the managed care organization to return a percentage of their tier to the state when medical loss ratios are below eighty-five percent. MO HealthNet estimates the savings to be $0 to unknown.

This minimum medical loss ratio risk mitigation strategy mitigates the State's risk that the capitation rates are over-priced, however, this does not address the health plan risk that capitation rates are under-priced. In terms of rate impacts, this arrangement may require additional risk/contingency load in the capitation rates. The cost is unknown.

MO HealthNet already reports some of the information required by this legislation, but not all of it, and it is not reported in the detailed format required by the proposal. In order to meet these requirements, MO HealthNet would need one additional staff at the Management Analysis Specialist II level, to collect, compile, analyze and report the data on a quarterly basis. It is assumed that FY15 would be for 10 months and include office/cubicle set up costs. In FY15, the cost for Personal Services, Fringe and Expense and Equipment would be $63,764. In FY16 and FY17 the cost would be $66,748 and $67,481, respectively.

This legislation requires that for services provided by MO HealthNet managed care organizations, that no prior authorization shall be required for the receipt of mental health testing and evaluation up to four hours. It is estimated that the rate impact would be less than $100,000.

Costs:
FY15: Greater than$288,764 (GR greater than $118,192; Federal greater than $170,572);
FY16: Greater than $266,748 (GR greater than $107,184; Federal greater than $159,564);
FY17: Greater than $267,481 (GR greater than $107,551; Federal greater than $159,930)

Savings:
FY15: $0
FY16: $0 to Unknown
FY17: $0 to Unknown

Bill as a Whole:

Officials from the **Department of Insurance, Financial Institutions and Professional Registration**, the **Department of Health and Senior Services**, the **Department of Social Services - Family Support Division**, the **Office of Administration (OA) - Division of Budget and Planning**, and the **OA - Information Technology Services Division** each assume the proposal would not fiscally impact their respective agencies.

HWC:LR:OD

ASSUMPTION (continued)

Officials from the **Office of Secretary of State (SOS)** state many bills considered by the General Assembly include provisions allowing or requiring agencies to submit rules and regulations to implement the act. The Secretary of State's office is provided with core funding to handle a certain amount of normal activity resulting from each year's legislative session. The fiscal impact for this fiscal note to the SOS for Administrative Rules is less than $2,500. The SOS recognizes this is a small amount and does not expect that additional funding would be required to meet these costs. However, it is also recognized that many such bills may be passed by the General Assembly in a given year and that collectively the costs may be in excess of what the office can sustain within its core budget. Therefore, the SOS reserves the right to request funding for the cost of supporting administrative rules requirements should the need arise based on a review of the finally approved bills signed by the governor.

In response to the previous version of this proposal, officials from the **Joint Commission on Administrative Rules (JCAR)** stated the legislation was not anticipated to cause a fiscal impact to JCAR beyond its current appropriation.

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
GENERAL REVENUE FUND			
Savings - DSS-MHD (§208.166)			
Program savings for statewide managed care implementation	$0	$5,202,890	$5,421,411
Savings - DSS-MHD (§208.999)			
Return of tier funding if medical loss ratio is less than 85%	$0	$0 to Unknown	$0 to Unknown
Costs - DSS-MHD (§208.166)			
Personal service costs	($125,404)	($152,051)	($153,572)
Fringe benefits	($63,963)	($77,554)	($78,329)
Equipment and expense	($48,683)	($16,773)	($17,192)
Packets, Actuarial and MMIS	(Greater than $439,500)	($114,500)	($114,500)
Total Costs - DSS-MHD	(Greater than $677,550)	($360,878)	($363,593)
FTE Change - DSS-MHD	4 FTE	4 FTE	4 FTE
Costs - DSS-MHD (§208.999)			
Personal service costs	($17,083)	($20,713)	($20,920)
Fringe benefits	($8,713)	($10,564)	($10,670)
Equipment and expense	($6,085)	($2,097)	($2,149)
Cost if capitation rates are underpriced	$0	$0 to (Unknown)	$0 to (Unknown)
Total Cost - DSS-MHD	($31,881)	(Could exceed $33,374)	(Could exceed $33,739)
FTE Change - DSS-MHD	0.5 FTE	0.5 FTE	0.5 FTE
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**(Greater than $709,431)**	**Could be less than $4,808,638**	**Could be less than $5,024,079**
Estimated Net FTE Change on the General Revenue Fund	4.5 FTE	4.5 FTE	4.5 FTE

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
OTHER STATE FUNDS			
Savings - DSS-MHD (§208.166)			
Program savings for statewide managed care implementation	$0	$3,309,642	$3,448,646
ESTIMATED NET EFFECT ON OTHER STATE FUNDS	**$0**	**$3,309,642**	**$3,448,646**
FEDERAL FUNDS			
Income - DSS-MHD (§208.166)			
Increase in program reimbursements	Greater than $677,550	$360,878	$363,593
Income - DSS-MHD (§208.999)			
Increase in program reimbursements	$31,881	Could exceed $33,375	Could exceed $33,739
Savings - DSS-MHD (§208.166)			
Reduction in program costs due to implementing statewide managed care	$0	$14,890,925	$15,516,344
Savings - DSS-MHD (§208.999)			
Return of tier funding if medical loss ratio is less than 85%	$0	$0 to Unknown	$0 to Unknown
Costs - DSS-MHD (§208.166)			
Personal service costs	($125,404)	($152,051)	($153,572)
Fringe benefits	($63,963)	($77,554)	($78,329)
Equipment and expense	($48,683)	($16,773)	($17,192)
Packets, Actuarial and MMIS	(Greater than $439,500)	($114,500)	($114,500)
Total Costs - DSS-MHD	(Greater than $677,550)	($360,878)	($363,593)
FTE Change - DSS-MHD	4 FTE	4 FTE	4 FTE

FISCAL IMPACT - State Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS (cont.)			
Costs - DSS-MHD (§208.999)			
Personal service costs	($17,083)	($20,713)	($20,920)
Fringe benefits	($8,713)	($10,565)	($10,670)
Equipment and expense	($6,085)	($2,097)	($2,149)
Cost if capitation rates are underprices	$0	$0 to (Unknown)	$0 to (Unknown)
Total Cost - DSS-MHD	($31,881)	(Could exceed $33,375)	(Could exceed $33,739)
FTE Change - DSS-MHD	0.5 FTE	0.5 FTE	0.5 FTE
Loss - DSS-MHD (§208.166)			
Reduction in program reimbursements due to implementing statewide managed care	$0	($14,890,925)	($15,516,344)
Loss - DSS-MHD (§208.999)			
Reduction in reimbursements if managed care organization has to return tier funding to state because medical loss ratio is less than 85%	$0	$0 to (Unknown)	$0 to (Unknown)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**
Estimated Net FTE Change on Federal Funds	4.5 FTE	4.5 FTE	4.5 FTE

FISCAL IMPACT - Local Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

Small business health care providers may experience increased reimbursement for services provided to Medicaid recipients if they belong to the managed care organization's network of providers.

HWC:LR:OD

FISCAL DESCRIPTION

This proposal changes the laws regarding MO HealthNet managed care services.

STATEWIDE MANAGED CARE (Section 208.166)

Effective July 1, 2015, the proposal requires the Department of Social Services to extend the MO HealthNet Managed Care Program statewide for all benefit and eligibility groups currently enrolled in a managed care plan as of January 1, 2014. The department must seek any necessary waivers or state plan amendments from the federal Department of Health and Senior Services and the pharmacy benefit for the managed care population receiving coverage under these provisions must remain covered under the MO HealthNet Fee-for-service Program. The department must develop a transitional Medicaid payment plan for the purpose of continuing and preserving payments consistent with current Medicaid levels for community mental health centers (CMHCs)and must also create an implementation working group consisting of CMHCs, the Department of Mental Health, and managed care organizations in the MO HealthNet Program.

The proposal prohibits a MO HealthNet managed care organization from refusing to contract with any licensed Missouri medical doctor, doctor of osteopathy, psychiatrist, or psychologist who is located within the geographic coverage area of a MO HealthNet managed care program and is able to meet the credentialing criteria established by the National Committee for Quality Assurance and is willing, as a term of contract, to be paid at rates not less than 100% of the MO HealthNet Medicaid fee schedule. All provisional licensed clinical social workers, licensed clinical social workers, provisional licensed professional counselors, and licensed professional counselors may provide behavioral health services to all participants in any setting. A MO HealthNet managed care organization is prohibited from refusing to contract with any provider under these provisions so long as the provider is located within the geographic coverage area of a MO HealthNet managed care program, is able to meet the credentialing criteria established by the National Committee for Quality Assurance, and is willing, as a term of contract, to be paid at rates equal to 100% of the MO HealthNet fee schedule. These provisions must not be construed to expand the scope of practice of provisional licensed clinical social workers, licensed clinical social workers, provisional licensed professional counselors, and licensed professional counselors.

For services provided by MO HealthNet managed care organizations, no prior authorization must be required for the receipt of mental health testing and evaluation up to four hours per member per year.

To aid the discovery of how and if MO HealthNet recipients covered under managed care organization health plans are improving in health outcomes and to provide data to the state to target health disparities, the State of Missouri must: (1) Provide a biannual analysis of each of

FISCAL DESCRIPTION (continued)

the state managed care organizations to ensure the organizations are meeting required metrics, goals, and quality measurements as defined in the managed care contract such as costs of managed care services as compared to fee-for-service providers and to provide the state with needed data for future contract negotiations and incentive management; (2) Meet all state health privacy laws and federal Health Insurance Portability and Accountability Act (HIPAA) requirements; and (3) Meet federal data security requirements.

JOINT COMMITTEE ON MO HEALTHNET (Section 208.952)

The Joint Committee on MO HealthNet is required to: (1) Meet on at least four occasions annually, including at least four before the end of December of the first year the committee is established. Meetings can be held by telephone or video conference at the discretion of the committee; (2) Review participant and provider satisfaction reports and reports of health outcomes, social and behavioral outcomes, and the use of evidence-based medicine and best practices in the MO HealthNet program; (3) Review the results from other states of the relative success or failure of various models of health delivery attempted; (4) Review the results of studies comparing various health plans; (5) Review the data from health risk assessments; (6) Review the results of public process input; (7) Advise and approve proposed design and implementation proposals for new health improvement plans submitted by the department, as well as make recommendations and suggest modifications when necessary; (8) Determine how best to analyze and present the data reviewed so that the health outcomes, participant and provider satisfaction, results from other states, health plan comparisons, financial impact of the various health improvement plans and models of care, study of provider access, and results of public input can be used by consumers, health care providers, and public officials; (9) Present significant findings of the analysis required in these provisions in a report to the General Assembly and Governor, at least annually, beginning January 1, 2016; (10) Study the demographics of the state and of the MO HealthNet population and how those demographics are changing; and (11) Perform other tasks as necessary including, but not limited to, making recommendations to the MO HealthNet Division within the Department of Social Services concerning the promulgation of rules and emergency rules so that quality of care, provider availability, and participant satisfaction can be assured.

MANAGED CARE REQUIREMENTS (Section 208.999)

MO HealthNet managed care organizations must be required to provide to the department, on at least a yearly basis, and the department must publicly report within 30 days of receipt, including posting on the department's website, at least the following information: (1) Medical loss ratios for each managed care organization compared with the 85% medical loss ratio for large group commercial plans under Public Law 111-148 and, where applicable, with the state's administrative costs in its fee-for-service MO HealthNet program; and (2) Total payments to the

FISCAL DESCRIPTION (continued)

managed care organization in any form including, but not limited to, tax breaks and capitated payments to participate in MO HealthNet, and total projected state payments for health care for the same population without the managed care organization. Managed care organizations must be required to maintain medical loss ratios of at least 85% percent, as defined by the National Association of Insurance Commissioners, for MO HealthNet operations. If a managed care organization's medical loss ratio falls below 85% over a cumulative period of three years, the managed care plan must be required to refund a portion of the capitation rates paid to the managed care plan in a tiered amount equal to the difference between the plan's medical loss ratio and 85% of the capitated payment to the managed care organization.

The department must be required to ensure that managed care organizations establish and maintain adequate provider networks to serve the MO HealthNet population and to include these standards in its contracts with managed care organizations. Managed care organizations must be required to establish and maintain health plan provider networks in geographically accessible locations in accordance with travel distances specified by the department in its managed care contracts and as required by the Department of Insurance, Financial Institutions and Professional Registration. Managed care plans' networks must consist of, at minimum, hospitals, physicians, advanced practice nurses, behavioral health providers, community mental health centers, substance abuse providers, dentists, emergent and non-emergent transportation services, federally qualified health centers, rural health centers, women's health specialists, local public health agencies, and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified by the Department of Social Services.

Managed care organizations must be required to post all of their provider networks on-line and must regularly update their postings of these networks on a timely basis regarding all changes to provider networks. A provider who is seeing only existing patients under a given managed care plan must not be listed. The Department of Social Services must be required to contract with an independent organization that does not contract or consult with managed care plans or insurers to conduct secret shopper surveys of MO HealthNet plans for compliance with provider network adequacy standards on a regular basis, to be funded by insurers out of their administrative budgets. Secret shopper surveys are a quality assurance mechanism under which individuals posing as MO HealthNet enrollees will test the availability of timely appointments with providers listed as participating in the network of a given plan for new patients. The testing must be conducted with various categories of providers, with the specific categories rotated for each survey and with no advance notice provided to the plan. If an attempt to obtain a timely appointment is unsuccessful, the survey records the particular reason for the failure, such as the provider not participating in MO HealthNet at all, not participating in MO HealthNet under the plan that listed it and was being tested, or participating under that plan but only for existing patients. Inadequacy of provider networks, as determined from the secret shopper surveys or the

ASSUMPTION (continued)

publication of false or misleading information about the composition of health plan provider networks, may be the basis for sanctions against the offending managed care organization. The provider compensation rates for each category of provider must also be reported by the managed care organizations to help ascertain whether they are paying enough to engage providers comparable to the number of providers available to commercially insured individuals, as required by federal law, and compared, where applicable, to the state's own provider rates for the same categories of providers.

Managed care organizations must be required to ensure sufficient access to out-of-network providers when necessary to meet the health needs of enrollees in accordance with standards developed by the department and included in the managed care contracts. Managed care organizations must be required to provide, on a quarterly basis and for prompt publication, at least the following information related to service utilization, approval, and denial: (1) Service utilization data, including how many of each type of service was requested and delivered, subtotaled by age, race, gender, geographic location, and type of service; (2) Data regarding denials and partial denials by managed care organizations or their subcontractors each month for each category of services provided to Medicaid enrollees. Denials include partial denials whereby a requested service is approved but in a different amount, duration, scope, frequency, or intensity than requested; and (3) Data regarding complaints, grievances, and appeals, including numbers of complaints, grievances, and appeals filed, subtotaled by race, age, gender, geographic location, and type of service, including the timeframe data for hearings and decisions made and the dispositions and resolutions of complaints, grievances, or appeals.

Managed care organizations must be required to disclose the following information: (1) Quality measurement data including, at minimum, all health plan employer data and information set (HEDIS) measures, early periodic screening, diagnosis, and treatment (EPSDT) screening data, and other appropriate utilization measures; (2) Consumer satisfaction survey data; (3) Provider satisfaction survey data; (4) Enrollee telephone access reports including average wait time before managed care organization or subcontractor response, busy signal rate, and enrollee telephone call abandonment rate; (5) Data regarding the average cost of care of individuals whose care is reported as having been actively managed by the managed care organization versus the average cost of care of the managed care organization's population generally. For purposes of these provisions, the phrase "actively managed by the managed care organization" means the managed care organization has actually developed a care plan for the particular individual and is implementing it as opposed to reacting to prior authorization requests as they come in, reviewing usage data, or monitoring doctors with high utilization; (6) Data regarding the number of enrollees whose care is being actively managed by the managed care organization, broken down by whether the individuals are hospitalized, have been hospitalized in the last 30 days, or have not recently been hospitalized; (7) Results of network adequacy reviews including geo-mapping, stratified by factors including provider type, geographic location, urban or rural areas, any

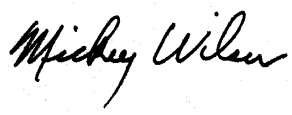
FISCAL DESCRIPTION (continued)

findings of adequacy or inadequacy, and any remedial actions taken. This information must also include any findings with respect to the accuracy of networks as published by managed care organizations, including providers found to be not participating and not accepting new patients; (8) Any data related to preventable hospitalizations, hospital-acquired infections, preventable adverse events, and emergency department admissions; and (9) Any additional reported data obtained from the managed care plans that relates to the performance of the plans in terms of cost, quality, access to providers or services, or other measures.

This legislation is not federally mandated, would not duplicate any other program but may require additional capital improvements or rental space.

SOURCES OF INFORMATION

Department of Insurance, Financial Institutions and Professional Registration
Department of Mental Health
Department of Health and Senior Services
Department of Social Services -
    Division of Legal Services
    Family Support Division
    MO HealthNet Division
Joint Commission on Administrative Rules
Office of Administration -
    Division of Budget and Planning
    Information Technology Services Division
Office of Secretary of State



Mickey Wilson, CPA
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April 3, 2014

HWC:LR:OD

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